

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003916	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/06/2014
NAME OF PROVIDER OR SUPPLIER AUTUMN GLEN ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 HARVEST MOON DR INDIANAPOLIS, IN 46229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint #IN00141945.</p> <p>Complaint #IN00141945 Unsubstantiated- due to lack of evidence.</p> <p>Date of Survey: February 6, 2014.</p> <p>Facility number: 003916 Provider number: 003916 AIM number: N/A</p> <p>Survey Team: Courtney Mujic, RN-TC Beth Walsh, RN</p> <p>Census bed type: Residential: 57 Total: 57</p> <p>Census payor type: Medicaid: 38 Other: 19 Total: 57</p> <p>Sample: 3</p> <p>Autumn Glen Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint #IN00141945.</p> <p>Quality Review 02/07/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE